Mecklenburg County Health Department
School Health Program

SICKLE CELL EMERGENCY ACTION PLAN

Name: ______________________________ Allergies: ______________

School: JOSEPH W. GRIER ACADEMY Year: 20-21 Grade: ________ Date of Birth: ____________

Homeroom Teacher: ______________ Room: ________ Student ID #: ______________

Parent/Guardian: ______________________________ Ph. (H) ______________

Address: ______________________________ Ph. (W) ______________

Parent/Guardian: ______________________________ Ph. (H) ______________

Address: ______________________________ Ph. (W) ______________

Emergency Phone Contact #1 ______________ ______________ ______________

Name Relationship Phone

Emergency Phone Contact #2 ______________ ______________ ______________

Name Relationship Phone

Physician treating student for Sickle Cell: ______________ Ph.: ______________

Other Physician: ______________ Ph.: ______________

EMERGENCY PLAN

(Fill in blanks, cross out and initial any steps not needed for this student.)

1. **Early warning signs of crisis:**
   - Joint pain, swelling or warmth in joint
   - Fatigue
   - Fever (greater that 101°)
   - Headache
   - Onset of pale color (pale fingernail beds, tissue around eyes)
   - Other: ______________________________
2. **Steps to take if early warning signs occur:**
   - Allow to rest
   - Encourage fluids
   - Contact parent/guardian
   - Other: ______________________________
3. **Emergency action is necessary when the student has symptoms such as:**
   - Severe generalized pain
   - Severe headache
   - One sided weakness, slurred speech
   - Abnormal behavior
   - Difficulty waking up, listless
   - Sudden significant cough
   - Chest pain
   - Abdominal swelling, abdominal pain
   - Other: ______________________________
4. **Steps to take during a Sickle Cell crisis:**
   - Contact parent/guardian or doctor's office
   - Encourage fluids, if alert
   - Call 911 and transport to ______________ Hospital
   - Other: ______________________________

Daily Management Plan:

1. Does your child wear a "Medic Alert"? Yes ________ No ________
   (This is highly recommended)

2. What medication is child currently taking?

   Name: ______________________________ Amount: ____________ Time of Day: ____________

   Name: ______________________________ Amount: ____________ Time of Day: ____________

3. Is there any medication taken for pain? Yes ________ No ________

   Name: ______________________________ Amount: ____________ Time of Day: ____________

4. Are there activities that your child CAN NOT participate in? ______________________________

   ____

5. Are there activities that bring on a pain crisis? Briefly describe. ______________________________

   ____

6. Has your child ever been hospitalized for crisis? If so, when? ______________________________

   ____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

Parent/Guardian Signature: ______________________________ Date: ______________

School Nurse Signature: ______________________________ Date: ______________

<u>This information will be shared with appropriate school staff unless you state otherwise.</u>

Important Information about Medication Admininstration in CMS Schools (7/31/2017)

School Name	School Phone #	Fax:	For School Use Only
		(704) 432-2079 (School Health)	Date Received/Receiver's Signature: Medication Received? ☐ yes ☐ no
Student's Name (Please print.)	Student's Date of Birth		Date Approved/Nurse's Signature Entered in EHR? ☐ yes ☐ no
Parent/guardian completes this form when medications are ordered on a form that is not the "Medication Authorization for CMS Students (version 04/25/17 rnl)". Parent/Guardian: Please read the information below. Fill in the contact information for your child's healthcare provider and parent/guardian contact information. Sign and date the form.			☐ Medication in Health Room ☐ Student Self Carries ☐ Emergency Medication in Classroom

Important Information about Medication Admininstration in CMS Schools

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.
- No medication will be given at school until the Medication Authorization form completed by the healthcare provider has been approved by a school nurse.
- Medications are given by a nurse or trained CMS staff.
- Unless changed in writing, medication orders will be used for the entire school year within which it was written.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.

Healthcare Provider's Name / Address / Phone / Fax	Parent/Guardian Contact Information (please print)	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools". I give permission for my child to receive the medications ordered by the healthcare provider during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about my child's medication(s) and health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking the medication(s) at school.

Write on line below.

Parent's/Guardian's Name (print)   Signature   Date

MEDICATION AUTHORIZATION FOR CMS STUDENTS

School Name	School Phone #	For School Use Only
		Date Received/Receiver's Signature:
If submitting by fax: 704-432-2079 (School Health)		Medication Received? ☐ yes ☐ no
Student's Name (Please print.)	Student's Date of Birth	Date Approved/Nurse's Signature
		Entered in EHR? ☐ yes ☐ no

Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- CMS action plans for asthma, diabetes, seizure disorders and severe allergies may be used instead of this form. See CMS Coordinated School Health webpage.
- When using this form, complete a separate form for each medication; write legibly; use lay terms.
- Complete Section 3 for students who will self-carry and/or self-medicate.

Medication: (Generic/Brand)	Controlled Substance? ☐ yes ☐ no
Dose/Dosing Instructions:	Route:
Administration Time: Relationship to meals: ☐ Not applicable ☐ With meals ☐ With snacks ☐ Other:	☐ PRN (specify time interval):
Purpose:	Check here if this medication is to be used for emergencies only. ☐
Side Effects/Adverse Reactions:	
Anticipated length of treatment: ☐ School Year ☐ _____ Months ☐ _____ Weeks ☐ ____ Days	Other Instructions (including emergency situations):

In my professional opinion, it is medically necessary for this student to receive this medication during school hours.

Signature of Healthcare Provider: ______________________________ **Date:** ____________________

Stamp, Print or Type Healthcare Provider's Name & Address	Office Phone
	Office Fax

SECTION 2: PARENT / LEGAL GUARDIAN CONSENT

- I understand: No medication will be given at school until this authorization has been approved by a school nurse. New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. It is my responsibility to supply the medication. Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use. Information about this medication and my child's health may be shared with school staff or agents of the school to help assure my child's safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health. Medications are given by a nurse or trained CMS staff.
- I give permission for my child to receive the medication described above during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health.
- On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Parent/Legal Guardian Signature:	Date:	Phone Numbers (mobile, work, home):
Parent/Legal Guardian (Print Name):		